

**~ ANKYLOSING SPONDYLITIS INJECTABLE MEDICATIONS ~****Prior Authorization Request Form**

Vermont Medicaid has established coverage limits and criteria for prior authorization of Ankylosing Spondylitis Injectable medications. These limits and criteria are based on concerns about safety when used with other medications, and efficacy. In order for beneficiaries to receive Medicaid coverage for these drugs, it will be necessary for the prescriber to telephone or complete and fax this prior authorization request to MedMetrics Health Partners. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

**Use this form for Ankylosing Spondylitis Injectable medication prior authorization requests only.**

**Submit request via: Fax: 1-866-767-2649 or Phone: 1-800-918-7549**

**Prescribing physician:**

Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

Fax #: \_\_\_\_\_

Address: \_\_\_\_\_

Contact Person at Office: \_\_\_\_\_

**Beneficiary:**

Name: \_\_\_\_\_

Medicaid ID #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

**Will this medication be billed via the:** ☐ **pharmacy benefit** or ☐ **medical benefit (J-code or other code)?****Pharmacy** (if known): \_\_\_\_\_ **Phone:** \_\_\_\_\_ **&/or FAX:** \_\_\_\_\_**Please select one of the following 'preferred' drug therapies from the VT Medicaid Preferred Drug List:**☐ **Enbrel** \_\_\_\_\_ Strength & Frequency: \_\_\_\_\_ Length of therapy: \_\_\_\_\_☐ **Humira** \_\_\_\_\_ Strength & Frequency: \_\_\_\_\_ Length of therapy: \_\_\_\_\_**For any other injectable Ankylosing Spondylitis treatment, please explain medical necessity for non-preferred product:****Drug:** \_\_\_\_\_ **Strength & Frequency:** \_\_\_\_\_ **Length of therapy:** \_\_\_\_\_**Medical justification:** \_\_\_\_\_**List previous medications tried and failed for this condition:**

Name of medication	Reason for failure	Date(s) attempted
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Prescriber comments:****Prescriber Signature:** \_\_\_\_\_**Date of this request:** \_\_\_\_\_